Medicaid 1915(c)
Home and Community-Based Services Waiver
for
Individuals Age 65 or Older

STATE IMPLEMENTATION PLAN

effective
July 1, 2005

Long Term Care Bureau
Division of Health Care Financing
Utah Department of Health

Approved by
CMS Region Office VIII
July 1, 2005

STATE OF UTAH
MEDICAID 1915(c) HOME AND COMMUNITY-BASED SERVICES WAIVER
for
INDIVIDUALS AGE 60 or OLDER

SECTION 1915(c) WAIVER FORMAT

1. The State of Utah requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

   This is a request for a model waiver.

   a. ___ Yes b. X No

   If yes, the State assures that no more than 200 individuals will be served on this waiver at any one time.

   This waiver is requested for a period of (check one):

   a. ___ 3 years (Initial waiver)

   b. X 5 years (Renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following level(s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

   a. X Nursing facility (NF)

   b. ___ Intermediate Care Facility for people with mental retardation (ICF/MR)

   c. ___ Hospital

   d. ___ NF (served in hospital)

   e. ___ ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

   a. X aged (age 65 and older)

   b. ___ disabled

   c. ___ aged and disabled

   d. ___ mentally retarded

   e. ___ developmentally disabled

   f. ___ mentally retarded and developmentally disabled

   g. ___ chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested in order to impose the following additional targeting restrictions (specify):

   a. ___ Waiver services are limited to the following age groups (specify):

   b. ___ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):

   c. ___ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by Public Law 100-203 to require active treatment at the level of care of an ICF/MR.

   d. ___ Other criteria specified in Appendix C-4.

   e. X Not applicable.

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.

6. This waiver program includes individuals who are eligible under medically needy groups.

   a. X Yes b. ___ No

7. A waiver of 1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy

a. X Yes b. ___ No c. ___ N/A

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.

a. ___ Yes b. X No

9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.

a. ___ Yes b. X No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in appendix B-1 of this request, be included under this waiver:

STATUTORY SERVICES

a. X Adult Day Health Services

b. X Homemaker Services

c. X Respite Care Services

d. X Respite Care – LTC Facility Services

e. X Waiver Case Management Services

EXTENDED STATE PLAN SERVICES

f. X Enhanced State Plan Supportive Maintenance Home Health Aide Services

OTHER SERVICES

g. X Adult Companion Services

h. X Chore Services

i. X Environmental Accessibility Adaptations

j. X Home Delivered Supplemental Meals

k. X Medication Reminder Systems

l. X Personal Attendant Services

m. X Personal Attendant Program Training

n. X Personal Emergency Response Systems Response Center Service

o. X Personal Emergency Response Systems Purchase, Rental, & Repair

p. X Personal Emergency Response Systems Installation, Testing & Removal

q. X Specialized Medical Equipment/Supplies/Assistive Technology

r. X Transportation Services (Non-medical)

SERVICES IN SUPPORT OF PARTICIPANT DIRECTION

12. The State assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.

13. A written service plan will be developed by qualified individuals for each individual served under this waiver. This service plan will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written service plan. The service plan will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the service plan. FFP will not be claimed for waiver services that are not included in the individual written service plan.

14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.

15. FFP will not be claimed in expenditures for the cost of room and board with the following exception(s) (Check all that apply):

a. X When provided as part of respite care in a facility approved by the

State that is not a private residence (hospital, NF, foster home, or community residential facility).

b. ___ Meals furnished as part of a program of adult day health services.

c. ___ When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver individual. FFP for rent and food for a live-in caregiver is not available if the individual lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3-meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to CMS:

a. Necessary safeguards have been taken to protect the health and welfare of the individuals receiving services under this waiver. Those safeguards include:

1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);

2. Assurance that the standards of any State licensing or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and

3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for the level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.)

c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:

1. Informed of any feasible alternatives under the waiver; and

2. Given the choice of either institutional or home and community-based services.

d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home and community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the waiver service(s) of their choice, or the provider(s) of their choice.

e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.

f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the setting(s) indicated in item 2 of this request~~,~~ in the absence of the waiver.

g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.

h. The agency will provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by CMS.

i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, Public Law 98-502.

i. X Yes ii. ___ No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to CMS at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a. ___ Yes b. X No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices) and the written quality management plan for this waiver. A copy of the quality management plan is on file at the State Medicaid Agency office. Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that service plans are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiency.

19. An effective date of July 1, 2005 is requested.

20. The State contact person for this request is Tonya Keller, who can be reached by telephone at (801) 538-9136.

This document, together with Appendices A through G, and all attachments, constitutes the State of Utah's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the Medicaid Single State Agency. Upon approval by CMS, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensing and certification requirements) will be kept on file at the Medicaid agency.

Signature: _____.

Print name: Michael Deily.

Title: Director, Division of Health Care Financing.

Renewal Request Date: March 31, 2005.

APPENDIX A - ADMINISTRATION

APPENDIX A-1: LINE OF AUTHORITY FOR WAIVER OPERATION

Check one:

___ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

X The Utah Department of Health, as the Medicaid Single State Agency, will be the administering agency for the waiver and will exercise administrative discretion in the administration and supervision of the waiver and issue all policies, rules and regulations related to the waiver. Through an interagency administrative agreement, the waiver operating agency will be the Division of Aging and Adult Services (DAAS), a separate agency of the State, under the supervision of the Medicaid Agency. In turn, DAAS may delegate activities of the operating agency to its affiliated Area Agencies on Aging (AAA)* through written contracts. A copy of the interagency agreement setting forth the authority and responsibilities of the administering agency and operating agency is on file at the Medicaid agency.

___ The waiver will be operated by _____, a separate division within the single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

*Note: In the event an Area Agency on Agency is unable to perform the responsibilities associated with administrative management of the HCBS Waiver operations, DAAS may contract with the Local Health Department to act in lieu of the Area Agency on Aging. The Local Health Department will perform according to all requirements established for Area Agencies on Aging related to the operation of the HCBS Waiver.

APPENDIX B - SERVICES AND STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

By providing immediate assistance to individuals with an identified need, the services covered by this waiver, as described below, serve to prevent institutionalization of these individuals. The cost-effectiveness of the covered services is demonstrated in Appendix G.

On an individual waiver enrollee basis, each covered waiver service will only be authorized when no other public funds, private funds, donations, or charitable funds are available to cover the cost of the service. It is the responsibility of the waiver case management agency to determine that no other funding source is available to the individual waiver enrollee and to document the funding resources explored and the reasons alternative funding is not available to the individual, if applicable.

STATUTORY SERVICES

X **Adult Day Health Services** serve the purpose of providing a supervised setting during which health and social services are provided on an intermittent basis to ensure the optimal functioning of the waiver participant.

Adult Day Health Services are generally furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the service plan. Meals provided as part of these services do not constitute a full nutritional regimen (3 meals per day).

Transportation between the individual's place of residence and the adult day care setting will be a separate component and not inclusive in the adult day care rate.

X **Homemaker Services** serve the purpose of maintaining a clean and sanitary living environment in the individual's residence.

Homemaker Services consist of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for those activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.

Limitation: Homemaker Services will not be provided when the involved activities duplicate activities concurrently being provided through another covered waiver service.

X **Respite Care Services** consist of care rendered by an attendant, companion, personal care worker, homemaker, home health aide etc., which is provided during the absence of, or to relieve the normal care giver while the covered individual is living in their normal place of residence and that residence is not a long term care facility. Respite care services are not restricted to the individual's place of residence.

Respite Care Services may be provided in the following locations:

X Individual's home or place of residence
X Licensed Adult Day Center;

Limitations: The provision of respite care will be provided through the following provider organizations as approved by the State:

Home Health Agency;
Personal Care Agency;
Area Agency on Aging;
Companion Service;
Homemaker Service;
Adult Day Health Provider.

X **Respite Care Services - LTC Facility** consist of care furnished in a licensed long term care facility during the absence of, or to relieve, the normal care giver. Each respite care episode is limited to a period of 13 consecutive days or less not counting the day of discharge.

Respite Care Services may be provided in the following locations:

X Licensed Health Care Facility
X Licensed Residential Treatment Facility

Limitations: Federal Financial Participation (FFP) will not be claimed for the cost of room and board except when provided as part of respite care in a facility approved by the State that is not the person's private residence.

X **Waiver Case Management** serves the purpose of maintaining the individual in the Home and Community-Based Services Waiver in accordance with program requirements and the person's assessed service needs, and coordinating the delivery of quality waiver services. Waiver Case Management consists of the following activities:
(a) Validate the initial comprehensive assessment and the initial comprehensive service plan for an individual newly enrolled in the waiver program,
(b) Consult with the agency responsible for waiver eligibility determination and enrollment to modify the initial comprehensive assessment and service plan as necessary;
(c) Research the availability of non-Medicaid resources needed by the individual to address needs identified through the comprehensive assessment process and assist the individual in gaining access to these resources, regardless of the funding source;
(d) Assist the individual to gain access to available Medicaid State Plan services necessary to address needs identified through the comprehensive assessment process;
(e) Assist the individual to select from available choices an array of waiver services to address needs identified through the comprehensive assessment process and to select from available choices providers to deliver each of the waiver services;
(f) Assist the individual to request a fair hearing if choice of waiver services or providers is denied;

(g) Monitor to assure the provision and quality of the services identified in the individual's service plan;
(h) Instruct the individual/legal representative/family how to independently obtain access to services when other funding sources are available;
(i) Monitor on an ongoing basis the individual's health and safety status and initiating appropriate reviews of service needs and service plans as needed;
(j) Coordinate with other Medicaid programs to achieve a holistic approach to care;
(k) Provide case management and transition planning services up to 90 days immediately prior to the date an individual transitions from a nursing facility to the waiver program;
(k) Provide discharge planning services to an individual disenrolling from the waiver.

ENHANCED STATE PLAN SERVICES

X **Enhanced State Plan Supportive Maintenance Home Health Aide Services** are provided in addition to home health aide services furnished under the approved State plan. These services are provided when home health aide services furnished under the approved State plan limits are exhausted. The scope and nature of these services do not differ from home health aide services furnished under the State plan and are defined in the same manner as provided in the approved State plan. The provider qualifications specified in the State plan apply. The additional amount of services that may be provided through the waiver is limited to the duration or frequency determined necessary through the comprehensive needs assessment process and delineated in the individual's service plan, but is not otherwise limited by definition in terms of duration or frequency.

Limitations: Supportive maintenance services will only be ordered after full utilization of available State Plan home health services by the individual.

OTHER SERVICES

X **Adult Companion Services** serve the purpose of supporting community activity and preventing social isolation.

Adult companion services involve non-medical care, supervision and socialization. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. The service is provided in accordance with a therapeutic goal in the service plan, and is not purely diversionary in nature.

Limitation: Adult Companion Services will not be provided when the involved activities duplicate activities concurrently being provided through another covered waiver service.

X **Chore Services** consist of heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress.

Limitations: These services will be provided upon approval of the Division of Aging and Adult Services or their designee and only in cases where the individual lacks the ability to perform or financially provide for the services, no other person is legally responsible to perform or financially provide for the services, and no other relative, caregiver, landlord, community/volunteer agency, third party payer, or other informal support system is willing and capable of providing the services. In the case of rental property, the responsibility of the landlord, pursuant to the lease arrangement, will be examined prior to any authorization of service. Chore Services will not be provided when the involved activities duplicate activities concurrently being provided through another covered waiver service.

X **Environmental Accessibility Adaptations** involve equipment and/or physical adaptations to the individual's residence which are necessary to assure the health, welfare and safety of the individual or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. The equipment/adaptations are identified in the individual's service plan and the model and type of equipment are specified by a qualified individual. The adaptations may include purchase, installation, and repairs. Authorized equipment/adaptations include:

a. Ramps
b. Grab bars
c. Widening of doorways/hallways
d. Modifications of bathroom/kitchen facilities
e. Modification of electric and plumbing systems which are necessary to accommodate the medical equipment, care and supplies that are necessary for the welfare of the individual.

General Limitations: Adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual are excluded. Adaptations which add to the total square footage of the home are excluded from this benefit. The case management agency will document all funding resources explored and reasons alternative funding is not available. Each environmental accessibility adaptation must be prior approved by the Division of Aging and Adult Services based on a determination of medical necessity. All services shall be provided in accordance with applicable State or local building codes.

Service Limit: The maximum allowable cost per environmental accessibility adaptation is $2,000.00. At the point a waiver participant reaches the service limit, the Division of Aging and Adult Services or their designee will conduct an evaluation to determine how the individual's health and safety can continue to be assured through authorization for additional service beyond the limit or alternative arrangements that meet the individual's needs while remaining in a community setting.

X **Home Delivered Supplemental Meal** provides a nutritionally sound and satisfying meal to individuals who are unable to prepare their own meals and who do not have a

responsible party or volunteer caregiver available to prepare their meals for them. Meals provided as part of this service shall not constitute a "full nutritional regimen" (3 meals per day).

Elements of Home Delivered Supplemental Meal Category: The Home Delivered Supplemental Meal category includes a prepared meal component and a nutritional supplement component. Either component constitutes a supplemental meal when provided in an amount that meets the nutritional needs of the individual. Each supplemental meal provided shall provide a minimum of 33 1/3 percent of the daily Recommended Dietary Allowances (RDA) and Dietary Reference Intake (DRI) as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences, Institute of Medicine and Mathematica Policy Research, Incorporated.

X **Medication Reminder System** provides a medication reminder by a third party entity or individual that is not the clinician responsible for prescribing and/or clinically managing the individual, not the entity responsible for the administration of medication, and not the entity responsible for the provision of nursing or personal care, attendant care, or companion care services. Services include non face-to-face medication reminder techniques (e.g. phone calls, telecommunication devices, medication dispenser devices with electronic alarms which alert the individual and a central response center staffed with qualified individuals, etc.)

The Medication Reminder System category covers only the ongoing service fee. Medication reminder system purchase or rental, installation, and testing are elements of the Specialized Medical Equipment/Supplies/Assistive Technology waiver service.

X **Personal Attendant Services** provide personal care and non-medical supportive services in the individual's place of residence specific to the needs of a medically stable elderly person. *This covered waiver service will incorporate a participant-directed approach with employer authority in which the individual or another duly appointed party under applicable laws of the State exercises control over specified staffing decisions relating to his or her personal attendant, including control over the selection and retention of the personal attendant, supervision of the attendant's activities, and verification of the personal attendant's time sheet. This service does not incorporate a participant-directed approach with budget authority.*

Personal Attendant services include physical and/or cognitive assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. This service may also include assistance with preparation of meals, but does not include the cost of the meals themselves, homemaker services, chore services, and assistance with instrumental activities of daily living that are incidental to the personal care furnished when the service is specified in the service plan as necessary to prevent institutionalization or to protect the health and safety of the individual waiver enrollee. Specific services outlined in the service plan must be coordinated with available State Plan personal care services and other covered waiver services to prevent concurrent provision of duplicate services.

Personal Attendant services are provided on a regularly scheduled basis.

Providers of Personal Attendant services may include family members who meet the specified provider qualifications when it is in the best interest of the individual served as determined by the Area Agency on Aging director or designee. Family members may not be reimbursed for Personal Attendant services that they are legally responsible to provide for the individual under State law.

Providers of Personal Attendant services may include agency-employed staff when the agency agrees to support the individual's control over specified staffing decisions relating to his or her personal attendant provided by the agency in keeping with the participant-directed orientation of this covered waiver service.

In the case of an individual who cannot direct his or her own personal attendant, another person may be appointed as the decision-maker in accordance with applicable State law. The appointed person must perform supervisory activities at a frequency and intensity specified in the service plan, but no less frequently than every 60 days. The individual or appointed person may also train the attendant to perform assigned activities.

Case Manager Responsibilities: At the time a waiver enrollee is determined to need the types of services provided by the Personal Attendant services category, the case manager will inform the individual of the scope and nature of the participant-directed service, including the option to directly employ the personal attendant or to utilize an agency-employed personal attendant, and the scope and nature of the Fiscal Management Agency that is used when the personal attendant is directly employed.

The case manager will document the adequacy of services provided by the personal attendant, additional training needed, and individual satisfaction with the services. A case file notation will be made regarding the adequacy of the services provided, any training or retraining necessary, and the continued appropriateness and feasibility of the attendant providing services. The case manager will arrange with contracted persons/agencies for all training needs of the personal attendants.

General Limitations: In the event it is determined that the individual is unable to adequately perform necessary supervisory activities and has no qualified appointed person to direct the personal attendant, alternative waiver services will be arranged by the waiver case manager utilizing appropriate agencies. Persons having case management involvement with the individual may not serve as surrogates responsible for directing the activities of the personal attendant. Payment will not be made for services furnished by the individual's spouse or other individuals who have a legal responsibility to furnish the services.

Personal Attendant services are to be a supplement to State plan Personal Care services and the amount, duration, and frequency of personal attendant services must take into account full utilization of State plan personal care services. Medicaid reimbursement is not available for Personal Attendant services performed for other members of the family

when the tasks go beyond that necessary to directly address the goal for the waiver enrollee specified in the service plan. Personal Attendant services will not be provided when the involved activities duplicate activities concurrently being provided through another covered waiver service.

Service Limit: Personal Attendant services will not exceed five (5) hours per day. At the point a waiver participant reaches the service limit, the Division of Aging and Adult Services or their designee will conduct an evaluation to determine how the individual's health and safety can continue to be assured through a time-limited authorization for additional service beyond the limit until alternative arrangements are made to meet the individual's needs while remaining in a community setting.

Fiscal Management Agency: *When the personal attendant is employed directly by the participant, the individual is required to use a Fiscal Management Agency to assist with managing the employer-related financial responsibilities associated with the participant-directed model.*

X **Personal Attendant Program Training Services** provide individualized training and instruction to the individual, family members, surrogates, and personal attendants. Training and instruction topics include explanation of the treatment regimes involved, proper performance of personal services, proper use of equipment, maintenance of a safe environment, and management activities associated with the employer/employee relationship. Training shall include updates as necessary to maintain the individual safely at home. Specific Personal Attendant Program Training services will be agreed upon by the individual and the waiver case manager and included in the service plan.

Limitations: Persons having case management involvement with an individual may not be providers of Personal Attendant Program Training Services to that individual.

X **Personal Emergency Response Systems (PERS) Response Center Service** serves the purpose of enabling the individual who has the skills to live independently or with minimal support to summon assistance in an emergency.

This service provides ongoing access to a signal response center that is staffed twenty-four hours per day, seven days a week by trained professionals responsible for securing assistance in the event of an emergency.

X **Personal Emergency Response System (PERS) Purchase, Rental & Repair** provides an electronic device of a type that allows the individual to summon assistance in an emergency. The device may be any one of a number of such devices but must be connected to a signal response center.

X **Personal Emergency Response System (PERS) Installation, Testing & Removal** provides installation, testing, and removal of the PERS electronic device by trained personnel.

X **Specialized Medical Equipment/Supplies/Assistive Technology** includes devices, controls, or other appliances which are of direct medical or remedial benefit to the individual and items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Automated, mechanical medication dispensing and reminder equipment are included when more simple methods of medication reminders are determined to be ineffective by the case manager. The need for such devices is specified in the individual's service plan. Reimbursement shall include the purchase, installation, removal, replacement, and repair of approved equipment, supplies, and adaptations.

General Limitations: Each item of specialized medical equipment, medical supplies, or assistive technology must be prior approved by the Division of Aging and Adult Services or their designee based on a determination of medical necessity and confirmation from the Medicaid Agency that the item is not available as a Medicaid State Plan benefit.

Service Limit: The maximum allowable cost per item is $500.00. At the point a waiver participant reaches the service limit, the Division of Aging and Adult Services or their designee will conduct an evaluation to determine how the individual's health and safety can continue to be assured through authorization for additional service beyond the limit or alternative arrangements that meet the individual's needs while remaining in a community setting.

X **Transportation Services (Nonmedical)** enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the service plan. This service is offered in addition to required medical transportation services and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's service plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

The necessary individual transportation service must be stipulated in the service plan with accompanying documentation provided in the case file establishing the need for the transportation to fulfill outcomes associated with another specific service listed in the service plan.

Limitations: Medicaid payment for transportation under the approved waiver plan is not available for medical transportation, transportation available thru the State plan, transportation that is otherwise available at no charge, or as part of administrative expenditures. Transportation services will be offered to individuals using the most cost effective and efficient method reasonably available within the individual's community.

SERVICES IN SUPPORT OF PARTICIPANT DIRECTION

APPENDIX B-2: PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensing regulations as specified in Utah Code Annotated (UCA) and Utah Administrative Code (UAC) are referenced by citation. Standards not addressed under uniform State citation are attached. Home and community-based waiver services are covered benefits only when delivered through individuals contracted with the Medicaid Single State Agency as evidenced by a signed Medicaid Provider Agreement or a Participant-directed Services Employer-Employee contract.

For purposes of this appendix, the term Medicaid Provider may be an individual contractor, professional agency, commercial business, or other organization.

Providers of covered waiver services are subject to background check provisions defined in Utah Code Annotated 26-21, 62A-2, and/or 62A-3, as applicable.

This waiver is operated without a companion Medicaid 1915(b) Freedom of Choice Waiver. All covered waiver services listed in Appendix B-1 may be provided by any willing provider that meets the specified qualifications listed in this Appendix and is enrolled with Medicaid program to provide the service and receive Medicaid reimbursement.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Adult Day Health Services	Medicaid provider enrolled to provide Adult Day Health Services.	Adult Day Center: UAC R501-13-1-13 or R432-150-6 or R432-270-29.		
Homemaker Services	Medicaid provider enrolled to provide Homemaker Services.	Current business license.		Demonstrated ability to perform the tasks ordered by the case management agency

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Respite Care Services	Medicaid provider enrolled to provide Respite Care Services.	Home Health Agency: UAC 432-700, **or** Adult Day Center: UAC R501- 13-1-13, **or** Other Organizations: Current business license.		Demonstrated ability to perform the tasks ordered by the case management agency
Respite Care Services (LTC Facility)	Medicaid provider enrolled to provide Respite Care Services (LTC Facility).	Nursing Facility: UAC R432-150, **or** Assisted Living Facility: UAC R432-270, **or** Residential Treatment Facility: UAC R501-19-13, **or** Swing Bed Unit: R432-100-4		
Waiver Case Management Services	Medicaid provider enrolled to provide Waiver Case Management Services.	RN: UCA 58-31b-301, **or** UCA 58-60-205	Certification through the National Academy of Certified Care Managers (CMC)	See Appendix B-2(E)
Enhance State Plan Supportive Maintenance Home Health Aide Services	Medicaid provider enrolled to provide Supportive Maintenance Home Health Aide Services.	Home Health Agency: UAC R432-700.		
Adult Companion Services	Medicaid provider enrolled to provide Adult Companion Services.	Current business license.		Demonstrated ability to perform the tasks ordered by the case management agency

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Chore Services	Medicaid provider enrolled to provide Chore Services.	Current business license.		Demonstrated ability to perform the tasks ordered by the case management agency
Environmental Accessibility Adaptations	Medicaid provider enrolled to provide Environmental Accessibility Adaptations.	Current business license **and** Contractor's license when applicable.		
Home Delivered Supplemental Meals	Medicaid provider enrolled to provide Supplemental Meal Service.	Current business license.		UAC R70-530.
Medication Reminder Systems	Medicaid provider enrolled to provide Medication Reminder Systems.	Current business license.		
Personal Attendant Services	Medicaid provider enrolled to provide Personal Attendant Services.			See Appendix B-2(C)
Personal Attendant Program Training	Medicaid provider enrolled to provide Personal Attendant Program Training.	RN: UCA 58-31b-301.		
Personal Emergency Response Systems Response Center Service	Medicaid provider enrolled to provide Personal Emergency Response Systems Response Center Service.	Current business license		24 hour per day operation, 7 days per week.
Personal Emergency Response Systems Purchase, Rental & Repair	Medicaid provider enrolled to provide Personal Emergency Response Systems Equipment.	Current business license, **and**		FCC registration of equipment placed in the individual's home.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Personal Emergency Response Systems Installation, Testing & Removal	Medicaid provider enrolled to provide Personal Emergency Response Systems Installation, Testing & Removal.			Demonstrated ability to properly install and test specific equipment being handled.
Specialized Medical Equipment/ Supplies/ Assistive Technology	Medicaid provider enrolled to provide Specialized Medical Equipment, Supplies, and/or Assistive Technology.	Current business license		
Transportation Services – Nonmedical	Medicaid provider enrolled to provide Nonmedical Transportation Services.	Licensed public transportation carrier, **or** Individual drivers license, **and**		Registered and insured vehicle: UCA 53-3-202, UCA 41-12a-301.

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensing or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the Medicaid Single State Agency, and the licensure and certification chart in B-2(A) must contain the precise citation indicating where the standards may be found.

For each service for which standards other than, or in addition to, State licensure or certification, are specified in B-2(A) must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are specified below.

Personal Attendant Services - Personal attendants will be authorized to provide specific services based on the individual's needs, the personal attendant's training and experience, and the degree and type of training and supervision required. In order to qualify as a Medicaid enrolled personal attendant, the applicant must be at least 18 years of age; have the ability to read, understand and carry out written and verbal instructions, write simple progress notes, demonstrate competency in all areas of assigned responsibility on an ongoing basis, and provide the Division of Aging and Adult Services or their designee with verification of a valid social security number and a copy of a current first aid certification from an accredited agency.

Personal attendants are subject to the requirements of Utah Code Annotated 26-21, 62A-2, and/or 62A-3, as applicable.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all available waiver service options and qualified providers of each service included in his or her written service plan.

E. ELIGIBILITY DETERMINATION, ENROLLMENT, AND SERVICE PLAN DEVELOPMENT SAFEGUARDS

The State Medicaid Agency will provide safeguards against potential problems that may arise from conflicts of interest related to the proper and efficient operation of the State Medicaid program, proper and efficient operation of the waiver program, and the arrangement for and provision of covered waiver services. The State has established the following safeguards for this waiver:

1. An agency that will perform both eligibility determination and enrollment activities and waiver case management activities must provide the State Medicaid Agency written documentation of controls that will be used to assure that staff having decision making authority and responsibility for determining applicants eligibility for the waiver program (and other Medicaid programs), waiver enrollees' eligibility for specific services, and applicants/enrollees' choice of participation in the Medicaid nursing facility program or the waiver program do not have overlapping responsibilities for waiver case management activities for the same waiver participants.

2. Provider organizations/individuals enrolled to perform the responsibilities of the Waiver Case Management covered service, as described in Appendix B-1, may not provide other direct waiver services except by special exemption granted by the Medicaid Agency. In the case where the Waiver Case Management provider is the only available provider for covered waiver services other than case management, and the Division of Aging and Adult Services or their designee has confirmed that no other non-Medicaid sources are available for the services, the Medicaid Agency may grant an exemption for the Waiver Case Management provider to also enroll as a provider of other specified covered waiver services.

APPENDIX B-3: KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

A. KEYS AMENDMENT ASSURANCE

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

B. APPLICABILITY OF KEYS AMENDMENT STANDARDS

Check one:

X Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

___ A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

APPENDIX C-ELIGIBILITY AND POST-ELIGIBILITY

APPENDIX C-1: ELIGIBILITY

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

1. ____ Low income families with children as described in section 1931 of the Social Security Act.

2. **X** SSI recipients (SSI Criteria States and 1634 States).

3. ____ Aged, blind or disabled in 209(b) States who are eligible under 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).

4. X Optional State supplement recipients.

5. **X** Optional categorically needy aged and disabled who have income at (Check one):

   a. **X** 100% of the Federal poverty level (FPL)

   b. ___% Percent of FPL which is lower than 100%.

6. **X** The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

   Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

   X A. Yes ___ B. No

Check one:

a. **X** The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b. ___ Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1) A special income level equal to:

___ 300% of the SSI Federal benefit (FBR)

___% of FBR, which is lower than 300% (42 CFR 435.236)

$___ which is lower than 300%

(2) ___ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3) ___ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435,324.)

(4) ___ Medically needy without spenddown in 209(b) States. (42 CFR 435.330)

(5) ___ Aged and disabled who have income at:

a. ___ 100% of the FPL

b. ___% which is lower than 100%.

(6) ___ Other (Include statutory reference only to reflect additional groups included under the State plan.)

7. **X** Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8. ____ Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

APPENDIX C-2--POST-ELIGIBILITY

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under 435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (435.217). For individuals whose eligibility is not determined under the spousal rules (1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR 435.726 and 435.735 just as it does for other individuals found eligible under 435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under 1924.

REGULAR POST-ELIGIBILITY RULES--435.726 and 435.735

- The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.

- If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.

- If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.

- If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY--1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of 1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in 1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as $30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The $30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the 1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

POST ELIGIBILITY

REGULAR POST ELIGIBILITY

1. **X** **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipient's income.

A. **435.726**--States which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A.___ The following standard included under the State plan (check one):

(1)___ SSI

(2)___ Medically needy

(3)___ The special income level for the institutionalized

(4)___ The following percent of the Federal poverty level):___%

(5)___ Other (specify):

_____

B.___ The following dollar amount:
$_____*

* If this amount changes, this item will be revised.

C. **X** The following formula is used to determine the needs allowance:

Up to $125 of any earned income plus an additional general disregard equal to the federal poverty limit for a household of one; plus a shelter cost deduction for actual mortgage & related costs (property taxes, insurance, etc.) or rent, not to exceed $300; & a utility cost deduction of $158 for households which have a heating or cooling expense, or $79 for a household which does not have a heating or cooling expense but has any other utility (water, phone, electricity, etc.). Total not to exceed the FFP limit.

Note: If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3**. following.

2. spouse only (check one):

A.___ SSI standard

B.___ Optional State supplement standard

C.___ Medically needy income standard

D.___ The following dollar amount:
$_____*

* If this amount changes, this item will be revised.

E.___ The following percentage of the following standard that is not greater than the standards above: ____% of standard.

F. **X** The amount is determined using the following formula:

A spousal allowance as determined under 1924 (d) of the Act.

G.___ Not applicable (N/A)

3. Family (check one):

A.___ AFDC need standard

B.___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.___ The following dollar amount:
$____*

*If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above: %___ of standard.

E._X_ The amount is determined using the following formula:

A family allowance, for each family member, equal to one-third (1/3) of the amount by which the minimum monthly needs allowance exceeds the amount of the monthly income of that family member.

F.___ Other

G.___ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

POST ELIGIBILITY

SPOUSAL POST ELIGIBILITY

2. **X** The State uses the post-eligibility rules of 1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual: (check one)

(a)___ SSI Standard

(b)___ Medically Needy Standard

(c)___ The special income level for the institutionalized

(d)___ The following percent of the Federal poverty level: ___%

(e)___ The following dollar amount $___**

**If this amount changes, this item will be revised.

(f) **X** The following formula is used to determine the needs allowance:

Up to $125 of any earned income plus an additional general disregard equal to the federal poverty limit for a household of one; plus a shelter cost deduction for actual mortgage & related costs (property taxes, insurance, etc.) or rent, not to exceed $300; & a utility cost deduction of $158 for households which have a heating or cooling expense, or $79 for a household which does not have a heating or cooling expense but has any other utility (water, phone, electricity, etc.). Total not to exceed the FFP limit.

(g)___ Other (specify):

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

APPENDIX C-3: COORDINATION OF MEDICAID ELIGIBILITY DETERMINATION AND LEVEL OF CARE DETERMINATION

Enrollment in the Home and Community-Based waiver is not permitted prior to the date the Medicaid applicant has been determined to meet eligibility for the Medicaid program and the level of care eligibility defined by the Medicaid program for Nursing Facility admission.

For purposes of the waiver program, documentation of the eligibility dates is accomplished through completion of the Form 927, Home and Community-Based Waiver Referral Form, including signature by both a Medicaid eligibility worker from the State and a representative of the Division of Aging and Adult Services or their designee. The Form 927 must specify the effective date of applicant's Medicaid eligibility and the date of the applicant's level of care determination.

Payment for Home and Community-Based waiver services are not permitted prior to the date the Medicaid applicant has been enrolled into the waiver except in the case of case management services involving discharge and transition planning provided to a Nursing Facility resident in the 90-day period immediately preceding his or her first day of admission to the waiver.

APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1: EVALUATION OF LEVEL OF CARE

The State Medicaid Agency, through the waiver operating agency, will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

The level of care determination will be based on clinical assessments of the waiver applicant performed by persons authorized by State law to perform such assessments. The clinical assessments must have been completed within the last 12 months. The persons performing the initial evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request will utilize the contents of available clinical assessments as the basis for the level of care determination.

Collection of the information needed to make the initial level of care determination will be done as a component of pre-enrollment eligibility determination as described in Appendix D-4(A). The level of care determination will be conducted in accordance with Appendix D-1(B).

A. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for individuals are (check all that apply):

___ Discharge planning team

___ Physician (M.D. or D.O.)

X Registered Nurse, licensed in the State

___ Social Services Worker, licensed in the State

___ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

___ Other (specify):

B. STATE OVERSIGHT OF LEVEL OF CARE DETERMINATION

The Medicaid Single State Agency has an interagency agreement authorizing the Division of Aging and Adult Services to certify the level of care for waiver applicants and enrollees. Staff of the Division of Aging and Adult Services, or their designee, performs first level monitoring of the level of care determination process. Final responsibility for oversight of the level of care determination process remains with the Single State Agency. The Medicaid Single State Agency retains authority to review any

initial level of care determination made by the Division of Aging and Adult Services, or its designees, and to make necessary modifications to the initial determination to arrive at a final level of care determination.

In accordance with the interagency agreement between the Medicaid Single State Agency and DAAS, an annual review is conducted of a sample of level of care determinations performed during the year, representative of the caseload distribution across the program. The specific sample size of each review is selected based on the identified focus of the review and the number of reviews determined to be necessary to evaluate the waiver's performance in the area of focus being monitored. If the sample evaluation identifies potential system-wide level of care problems, an expanded review is initiated by the Medicaid Single State Agency.

APPENDIX D-2: REEVALUATIONS OF LEVEL OF CARE

A. FREQUENCY OF REEVALUATIONS

Reevaluations of the level of care required by the individual will take place (at a minimum) according by the following schedule (specify):

___ Every 3 months

___ Every 6 months

___ Every 12 months (or more often as needed)

X Other (specify): The individual's level of care is screened at the time a substantial change in the individual's health status occurs to determine whether the individual's resultant health status constitutes an ongoing nursing facility level of care, including at the conclusion of an inpatient stay in a medical institution.

A full level of care reevaluation is conducted whenever indicated by a health status change screening and as a minimum within 12 consecutive months of the last recorded level of care determination.

B. QUALIFICATIONS OF EVALUATORS PERFORMING REEVALUATIONS

Check one:

X The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

___ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care. (Specify.)

___ Physician (M.D. or D.O.)

___ Registered Nurse, licensed in the State

___ Licensed Social Worker

___ Qualified Mental Retardation Professional, as defined in Appendix B1 of this document

___ Other (specify):

C. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (check all that apply):

___ "Tickler" file

___ Edits in computer system

_X_ Component part of the Division of Aging and Adult Services, or their designees, eligibility determination coordination process

___ Other (specify):

APPENDIX D-3: MAINTENANCE OF RECORDS

A. LOCATION OF RECORDS

1. Record of evaluations and reevaluations of level of care will be maintained in the following locations (check all that apply):

   ___ In the Medicaid agency in its central office

   ___ In the Medicaid agency in district/local offices

   X In the agency designated in Appendix A as having primary responsibility for the daily operations of the waiver program

   X In the individual's waiver case record maintained by the case management agency

   ___ In the files of the person(s) or agencies designated as responsible for the performance of evaluations and reevaluations

   ___ By service providers

   ___ Other (specify):

2. Written documentation of all evaluations and reevaluations will be maintained as described in this appendix for a minimum period of 3 years.

B. COPIES OF FORMS AND CRITERIA FOR EVALUATION / ASSESSMENT

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

X The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

The InterRAI MINIMUM DATA SET - HOME CARE (MDS-HC©) serves as the standard comprehensive assessment instrument for this waiver and includes all the data fields necessary to measure the individual's level of care as defined in the State's Medicaid nursing facility admission criteria. Persons responsible for collecting the needed information and for making the initial level of care determination are trained by staff of the administering agency or the Division of Aging and Adult Services in the proper application of the MDS-HC instrument

and the proper analysis of the MDS-HC data to evaluate level of care eligibility. The standard assessment instrument is used for all waiver applicants regardless of whether they are residing in an institution or in a community setting.

___ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons (specify).

APPENDIX D-4: FREEDOM OF CHOICE AND FAIR HEARING

A. CHOICE OF MEDICAID LTC PROGRAM

1. The Division of Aging and Adult Services or their designee evaluates whether the individual will likely require the nursing facility level of care, assesses the individual's general LTC needs, and provides information to the individual about the types of services available through the waiver and through the Medicaid nursing facility program as part of a pre-enrollment education and screening process.

2. When an individual is determined to be likely to require the nursing facility level of care and the Division of Aging and Adult Services or their designee determines that the individual can adequately be served in the community, the person or the person's legal representative is:

   a. Informed of any feasible alternatives under the waiver; and

   b. Given the choice of either institutional or home and community-based services.

3. The individual is informed that the Medicaid Single State Agency provides an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to nursing facility institutional care.

4. Written documentation of the individual's choice of LTC program and acknowledgement of the right to a fair hearing is maintained in the individual's case record.

B. RESPONSE TO CLAIM FOR MEDICAID ASSISTANCE

1. Upon the individual's choice of home and community-based services, the Division of Aging and Adult Services or their designee conducts a comprehensive assessment in response to the individual's request for Medicaid assistance. The comprehensive assessment identifies: (a) the individual's needs related to assuring health, welfare, and safety in a home or community setting in lieu of institutionalization (claim for assistance) and (b) the individual's goals related to enhancing community integration and quality of life (personal desires).

2. The individual is informed of the results of the assessment and the specific needs identified as related to assuring health, welfare, and safety in a home or community setting in lieu of institutionalization (claim for assistance).

3. The individual is informed that the Medicaid Single State Agency provides an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to individuals

who are not advised of the results of the comprehensive assessment or feel the assessment results do not accurately reflect the individual's needs related to assuring health, welfare, and safety in a home or community setting in lieu of institutionalization (claim for assistance).

4. Written documentation of the individual's acknowledgement that the Division of Aging and Adult Services or their designee fully disclosed the results of the comprehensive assessment and the right to a fair hearing is documented in accordance with Appendix D-4(C).

5. From the comprehensive assessment, a written service plan is developed by the Division of Aging and Adult Services or their designee in accordance with Appendix E to address the individual's identified needs through a specified array of services and supports. At the option of the agency, the written service plan may also incorporate other optional services and supports that are not primary to preventing institutionalization or protecting health and safety but will contribute in assisting the individual to achieve personal goals for independence and community integration. The service plan will identify these other services and support as optional and will identify funding sources other than Medicaid to cover any associated costs.

C. CHOICE AND FAIR HEARING PROCEDURES AND FORMS

1. The following are attached to this Appendix:

   a. A copy of the form used to document the individual's choice of Medicaid LTC program and the individual's acknowledgment of disclosure of information about the right to a fair hearing;

   b. A copy of the form used to request a fair hearing;

   c. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E; and

   d. A description of the State's procedures for conducting administrative hearings.

MEDICAID 1915c HCBS WAIVER FOR INDIVIDUALS AGE 65 OR OLDER

DOCUMENTATION OF LTC PROGRAM CHOICE AND RIGHT TO FAIR HEARING

Individual Name: _____ **Social Security Number:** _____.

CHOICE OF LTC PROGRAM

I have been fully informed of services available through the Medicaid Home and Community-Based Services Aging Waiver Program. I have also been fully informed of services available in a nursing facility.

After receiving explanations regarding the choices available, I freely choose to:

___ Receive services through the Medicaid Home and Community-Based Aging Waiver Program.

___ Receive services in Medicaid certified nursing facility.

_____ _____

Individual/Representative Signature Date **Agency Representative Signature Date**

RIGHT TO FAIR HEARING AND APPEAL - As a potential recipient of services through the Title XIX Home and Community-Based Services Aging Waiver, you have the right to appeal an alleged adverse action in regard to your participation in the program, including a denial of your application for participation in the Medicaid 1915c Home and Community-Based Waiver program or denial of your choice to participate in either the Medicaid Sate Plan nursing facility program or the Medicaid 1915c Home and Community-Based Waiver program. If you disagree with a decision in regard to your participation, you have the right to a hearing on the matter.

You (or your representative) have 30 days following the date the notice of decision is mailed to request a fair hearing. To file an appeal, you may contact the Department of Health, Division of Health Care Financing, Formal Hearings at 538-6406. You will be advised of the procedures and assisted in completing the appeal form. The appeal request must be in writing. Once you have filed the appeal, arrangements for a hearing will be made and you will be notified of the time and place. You may represent yourself at the hearing or be represented by another person including legal counsel, if you so choose.

_____ _____

Individual/Representative Signature Date **Agency Representative Signature Date**

REQUEST FOR HEARING/AGENCY ACTION

NAME OF PROVIDER/PATIENT OR INDIVIDUAL/APPLICANT REQUESTING HEARING:

NAME: _____

ADDRESS: _____

Social Security Number: ___/___/____. Individual I.D. or Provider # (if known): _____

Date of Service (if known) _____ Medicaid program _____

1. The relief or action sought from the agency (the reason you are requesting a hearing) is:

2. The facts and reasons forming the basis for relief of agency action (the reasons you believe you are entitled to a hearing) are:

3. The names and addresses of all persons to whom you are sending a copy of this request for a hearing:

Name: _____ Address: _____

Name: _____ Address: _____

PLEASE ENCLOSE A COPY OF THE DENIAL NOTICE THAT CAUSED YOU TO REQUEST THIS HEARING. THIS IS VERY IMPORTANT. WITHOUT THIS INFORMATION YOUR HEARING COULD BE DELAYED.

THIS REQUEST MUST BE FILED WITH THE DIRECTOR'S OFFICE/FORMAL HEARINGS, DIVISION OF HEALTH CARE FINANCING WITHIN 30 DAYS OF THE DATE A DENIAL NOTICE IS ISSUED. A COPY OF THIS REQUEST MUST BE MAILED TO EACH PERSON KNOWN TO HAVE A DIRECT INTEREST IN THE REQUESTED AGENCY ACTION.

IF YOU WILL BE REPRESENTED BY AN ATTORNEY, THE ATTORNEY MUST FILE A NOTICE OF APPEARANCE IMMEDIATELY. If the Division of Health Care Financing does not receive notice at least ten calendar days before any scheduled hearing that an attorney for the petitioner will be present, the hearing may be rescheduled.

Attorney Representation? YES NO (circle)
NAME OF ATTORNEY/REPRESENTATIVE: _____

Address: _____ Phone #: _____

_____ Phone #: _____
Please print name of person requesting hearing

_____ _____
Signature of person requesting hearing Date

SEND REQUEST TO: DIRECTOR'S OFFICE/FORMAL HEARINGS
DIVISION OF HEALTH CARE FINANCING
P.O. Box 143105
SALT LAKE CITY, UT 84114-3105

ADMINISTRATIVE HEARING PROCEDURES

All hearings before the Division of Health Care Financing except as otherwise set forth shall be conducted as a formal hearing.

Advance Notice

A. Each individual who is affected by an adverse action taken by the Medicaid Single State Agency or the Division of Aging and Adult Services will be given advance notice of such action:

B. A notice must contain:

1. A statement of the action the agency intends to take;
2. The date the intended action takes effect;
3. The reasons for the intended action;
4. The aggrieved person's right to request a formal hearing before DHCF, when applicable, and the method by which such hearing may be obtained from DHCF;
5. A statement that the aggrieved person may represent himself or use legal counsel, relative, friend, or other spokesman at the formal hearing; and,
6. An explanation of the circumstances under which Medicaid coverage or reimbursement will be continued if a formal hearing is timely requested.

C. DHCF will mail an advance notice at least ten calendar days before the date of the intended action.

Request for Formal Hearing

A. An aggrieved Medicaid applicant/recipient/provider may request a formal hearing within 30 calendar days from the date written notice is issued or mailed, whichever is later, by DHCF of an action or inaction.

B. Failure to submit a timely request for a formal hearing will constitute a waiver of a person's formal hearing or pre-hearing rights. A request for a hearing shall be in writing, shall be dated, and shall explain the reasons for which the hearing is requested.

C. The address for submitting a "Request for Hearing/Agency Action" is as follows:

Division of Health Care Financing
Attention: Formal Hearings
P.O. Box 143105
Salt Lake City, UT 84114-3105

Fax # : 801-538-6412

Reinstatement/Continuation of Services

1. DHCF may reinstate services for individuals or suspend any adverse action for individuals/providers if an aggrieved person requests a formal hearing not more than ten (10) calendar days after the date of action.

2. DHCF must reinstate or continue services for individuals or suspend adverse actions for providers until a decision is rendered after a formal hearing if:

    a. Adverse action is taken without giving the ten-day advanced mailed notice to an individual/provider in all circumstances where such advance notice is required;

    b. In those circumstances where advance notice is not required, the aggrieved person requests a formal hearing within ten calendar days following the date the adverse action notice is mailed; or

    c. DHCF determines that the action resulted from other than the application of federal or state law or policy.

APPENDIX D-5: REVIEW PROTOCOLS FOR WAIVER DISENROLLMENT

The Division of Health Care Financing (DHCF) in partnership with the Division of Aging and Adult Services will compile information on voluntary disenrollments, and routine involuntary disenrollments and will conduct reviews of proposed special circumstance disenrollments from the waiver.

1. Voluntary disenrollments are cases in which individuals choose to initiate disenrollment from the waiver and provide written notice of their decision and the planned effective date. These cases require written notification to the Division of Health Care Financing by the Division of Aging and Adult Services within 30 days from date of disenrollment. Documentation will be maintained by the Division of Aging and Adult Services detailing the discharge planning activities completed with the individual as part of the disenrollment process.

2. Pre-Approved involuntary disenrollments are cases in which individuals are involuntarily disenrolled from a home and community based waiver program for one or more of the specific reasons listed below:

    a. Individual death;

    b. Individual no longer meets financial requirement for Medicaid program eligibility;

    c. Individual has moved out of the State of Utah; or

    d. Individual whereabouts are unknown.

3. Pre-Approved involuntary disenrollments require written notification to the Division of Health Care Financing by the Division of Aging and Adult Services within 30 days from date of disenrollment. No Division of Health Care Financing prior review or approval of the decision to disenroll is required. Documentation will be maintained by the Division of Aging and Adult Services detailing the discharge planning activities completed with the individual as part of the disenrollment process, as appropriate.

4. Special circumstance disenrollments are cases that are non-routine in nature and involve circumstances that are specific to the individual involved. Examples of this type of disenrollment include the individual no longer meets the corresponding institutional level of care requirements, the individual's health and safety needs cannot be met by the current program's services and supports, or the individual has demonstrated non-compliance with the agreed upon service plan and is unwilling to negotiate an service plan that meets minimal safety standards.

5. Special circumstance disenrollments require review and authorization prior to disenrollment to facilitate:

    a. Appropriate movement among programs;

    b. Effective utilization of program potential;

    c. Effective discharge and transition planning;

    d. Provision of information, affording individuals the opportunity to exercise all rights; and

    e. Program quality assurance/quality improvement management.

6. The special circumstance disenrollment review process will consist of the following activities:

    a. The waiver case management agency recommending disenrollment will compile information to articulate the disenrollment rationale.

    b. The waiver case management agency will then submit the information to the Division of Aging and Adult Services designee for review of the documentation of case management activities and of the disenrollment recommendation. The Division of Aging and Adult Services designee will consult with DAAS to make an initial determination on the merits of the proposed disenrollment.

    c. If DAAS management staff concurs with the recommendation, the case will be forwarded to the DHCF for a final decision.

    d. The DHCF will review and assure the available array of Medicaid waiver and non-waiver services, and other available resources have been fully utilized to meet the individual's health and safety needs.

    e. The DHCF will facilitate case staffing meetings with appropriate parties, as needed, to complete the review and make an appropriate final decision on the proposed disenrollment.

    f. The DHCF final disenrollment decision will be communicated in writing to both the Division of Aging and Adult Services designee and the DAAS management staff.

7. If the disenrollment is approved, the Division of Aging and Adult Services designee will provide the individual the required written notification of agency action and right to fair hearing information.

8. The case management agency will initiate discharge planning activities sufficient to assure smooth transition to an alternate Medicaid program or to other services.

APPENDIX E – SERVICE PLAN

APPENDIX E-1: SERVICE PLAN DEVELOPMENT

1. The following individuals are responsible for the preparation of the service plans:

   _X_ Registered nurse, licensed to practice in the State, or

   _X_ Division of Aging and Adult Service or their designee team consisting of Registered Nurse and Social Services Worker

   ___ Licensed practical or Vocational nurse, acting within the scope of practice under State law

   ____ Physician (M.D. or D.O.) licensed to practice in the State

   ____ Social Worker (qualifications attached to this Appendix)

   ____ Other (specify):

2. Copies of written service plans will be maintained for a minimum period of 3 years. Specify each location where copies of the service plans will be maintained.

   ____ At the Medicaid agency central office

   ____ At the Medicaid agency county/regional offices

   ___ By case managers

   _X_ By the agency specified in Appendix A

   _X_ Other (specify): In the individual's waiver case record maintained by the case management agency

3. The service plan is the fundamental tool by which the State will ensure the health and welfare of the individuals. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability.

   The minimum schedule under which these reviews will occur is:

   _____ Every 3 months

   _____ Every 6 months

   _____ Every 12 months

X Other (specify): The individual's service plan is screened at the time a substantial change in the individual's health status occurs to determine whether modifications to the service plan are needed.

A full service plan review is conducted:

a. Whenever indicated by the results of a health status change screening;

b. In conjunction with completion of a full comprehensive assessment;

c. At a minimum within 12 consecutive months of the last recorded full service plan review.

APPENDIX E-2: MEDICAID AGENCY APPROVAL

A. SERVICE PLAN DEVELOPMENT

The following is a description of the process by which the service plan is made subject to the approval of the Medicaid agency:

1. The InterRAI MINIMUM DATA SET - HOME CARE serves as the standard comprehensive assessment instrument. A copy of the instrument is maintained at the Medicaid Single State Agency.

   The standard comprehensive assessment determines the individual's need for a set of specific services and supports related to assuring health, welfare, and safety in a home or community setting in lieu of institutionalization. The assessment provides a broad review of the individual and identifies the current needs to be addressed. The comprehensive assessment is conducted by the Division of Aging and Adult Services or their designee at the time a significant change in the individual's status occurs and at a minimum within 12 consecutive months of the last recorded comprehensive assessment.

2. A written service plan is developed by the Division of Aging and Adult Services or their designee for each individual who receives Home and Community-Based waiver services. The service plan describes the type, amount, frequency and duration of services to be furnished, the type of provider who will furnish each service, and the outcomes to be achieved in response to each service. The service plan is developed in consultation with the individual, the individual's legal representative, the individual's selected case manager, and others as necessary and appropriate. The plan outlines an approach for delivering services, supports and life activities to meet the needs of the individual and prevent institutionalization.

   During the preparation of the written service plan the individual will be informed of the array of waiver services and supports available to address the identified needs and the service provider options available for each service and supported in the array. The individual will be given a choice of available waiver service providers.

3. On an on-going basis throughout the year the case manager and individual coordinate to review the progress toward the desired intended outcomes, service utilization and ongoing appropriateness of current services, and budget expenditures.

   This ongoing coordination may lead to service utilization patterns that change on a frequent basis. The flexibility to review and adjust the service plan allows the individual to utilize services in a way that best meets identified needs, is responsive to consumer choice, and is responsive to fluctuations that occur in

service need. This ongoing coordination also enables the case management agency to monitor progress toward intended outcomes and to make recommendations to the Division of Aging and Adult Services or their designee for adjustments to the service plan to maximize the effectiveness and efficiency of the individualized approach to care.

During the review of the written service plan the individual will be informed in writing of any decision to deny, suspend, reduce, or terminate a waiver service listed in the service plan and will be informed of the right to a fair hearing.

4. The Division of Aging and Adult Services, through an interagency agreement with the Medicaid Single State Agency, is delegated first level responsibility to review and approve written service plans as part of its state monitoring responsibility.

5. The Medicaid Single State Agency retains final authority for oversight and approval of the service planning process as set forth in Section G of the interagency agreement between the Medicaid Single State Agency and DAAS. The oversight function involves at a minimum an annual review of a sample of waiver enrollee's service plans that is representative of the caseload distribution across the program. The specific sample size of each review is selected based on the identified focus of the review and the number of reviews determined to be necessary to evaluate the waiver's performance in the area of focus being monitored. If the sample evaluation identifies potential system-wide level of care problems, an expanded review is initiated by the Medicaid Single State Agency.

B. SERVICE PLAN CONTENT

The service plan will contain, at a minimum, the following information:

1. Service plan effective date;

2. Name of individual receiving waiver services;

3. Address;

4. Case manager's name and office location;

5. Division of Aging and Adult Services or their designees' RN's name and office location;

6. List of all waiver services to be provided to the individual, including case management when applicable, and all other needed services identified through the comprehensive assessment process, regardless of funding source;

7. The amount, frequency and duration for each service;

8. The intended outcome to be achieved during the duration of each service;

9. The type of qualified provider(s) selected to furnish each service;

10. Expected start date of each service;

11. Signatures of the individual receiving services, the Division of Aging and Adult Services or their designee RN, the individual's case manager, and the individual's legal representative, when applicable.

C. SERVICE PLAN FORMAT

A standard service plan format is used for all waiver service plans. A copy of the instrument is on file at the Medicaid Single State Agency.

D. CASE MANAGEMENT ENCOUNTERS

To better focus primary attention on providing the specific level of case management intervention needed on an individualized basis, as determined during the initial and ongoing comprehensive needs assessment process, the service plan will be the vehicle through which the level of assessed need for case management will be detailed in terms of the objectives to be achieved, and the scope, duration, and frequency of intervention to be provided to meet the stated objectives. This approach will also promote case managers having specific information about their expected roles and responsibilities on an individualized waiver individual basis. Program performance reviews will be conducted by the administering agency and the Division of Aging and Adult Services or their designee to assess the accuracy and effectiveness of the link between the determination of need, the service plan, the implementation of case management services, and the ongoing evaluation of progress toward the stated objectives.

E. INDIVIDUAL'S ACKNOWLEDGEMENT OF RIGHT OF CHOICE AND RIGHT TO A FAIR HEARING

1. The individual is informed that the Medicaid Single State Agency provides an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to individuals who feel the comprehensive assessment does not accurate identify the array of needs that must be addressed in order to assure health, welfare, and safety in a home or community setting in lieu of institutionalization.

2. The individual is informed that the Medicaid Single State Agency provides an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to individuals who feel the written service plan does not provide access to waiver services necessary to assure health, welfare, and safety in a home or community setting in lieu of institutionalization, or feels a choice of available providers for the services and supports listed in the written service plan was not provided.

3. The individual will acknowledge on the written service plan that he or she has been informed of the array of waiver services available to address the needs identified through the comprehensive assessment process and the service provider options available for each selected waiver service listed on the service plan.

APPENDIX F - AUDIT TRAIL

A. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.

2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

   X Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

   ____ Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

   ____ Payment for waiver services will not be made through an approved MMIS. A description of the process by which payment are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

   ____ Other (Describe in detail):

B. BILLING PROCESS AND RECORDS RETENTION

1. Following on pages F-3 and F-4 is a description of the billing process used for this waiver. Included is a description of the mechanism in place to assure that all claims for payment of waiver services are made only:

    a. When the individual was eligible for Medicaid waiver payment on the date of service;

    b. When the service was included in the approved service plan;

    c. In the case of supported employment or education services included as part of support services, when the individual was eligible to receive the services, and the services are not available to the individual through a program funded under section(s)(15) and (17) of the Individuals with Disabilities Education Act (IDEA) or section 110 of the Rehabilitation Act of 1973.

        ___ Yes.

        _X_ No. These services are not included in the waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

    _X_ All claims are processed through an approved MMIS.

    ___ MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A, and providers of waiver services for a minimum period of 3 years.

DESCRIPTION OF BILLING PROCESS AND RECORDS RETENTION

1. An individual's Medicaid eligibility is determined by the Office of Health and Eligibility within the Department of Workforce Services or the Bureau of Eligibility Services within the Department of Health. The information is entered into the Public Assistance Case Management Information System (PACMIS). PACMIS is an on-line, menu-driven system which automates Medicaid eligibility decisions, benefits amounts, individual notices and administrative reports. PACMIS interfaces with other governmental agencies such as, Social Security, Employment Security, and the Internal Revenue Service. The system is a Federally-Approved Management Information System (FAMIS). In Utah, the following programs are accessed through PACMIS: Aid to Families with Dependent Children (AFDC), Medicaid, Food Stamps, and two state-administered programs - General Assistance and the Utah Primary Care Network (PCN). The Medicaid Management Information System (MMIS) accesses PACMIS to ensure the individual is Medicaid eligible before payment of claims is made.

2. Post-payment reviews are conducted in accordance with the procedures outlined in Appendix E-2. The Medicaid agency reviews a sample of individual written service plans and Medicaid claims histories to ensure: (1) all of the services required by the individual are identified in the service plan, (2) that the individual is receiving the services identified in the service plan, and (3) that Medicaid reimbursement is not claimed for waiver services which were not included in the service plan.

3. Prior to the order and delivery of Medicaid reimbursed approved specialized medical equipment, medical supplies, or assistive technology, the case coordinator must obtain prior approved based on a determination of medical necessity and a determination that the item is not available as a Medicaid State Plan service.

4. The participant-directed model for Personal attendant services requires the individual to use a Waiver Fiscal Management Agency as an integral component of the waiver service to assist with managing the employer-related financial responsibilities associated with the self-directed employee model. The Waiver Fiscal Management Agency is a person or organization that assists waiver enrollees and their representatives, when appropriate, in performing a number of employer-related tasks, without being considered the common law employer of the enrollees' service workers. Tasks performed by the Waiver Fiscal Management Agency include documenting service workers' qualifications, collecting service worker time records, preparing payroll for enrollees' service workers, and withholding, filing and depositing federal, state, and local employment taxes.

   Participant-directed service workers complete a time sheet for work performed. The individual confirms the accuracy of the time sheet, signs it, and forwards it to the Waiver Fiscal Management Agency for processing. The Waiver Fiscal

Management Agency files a claim for reimbursement on behalf of the service worker through the Medicaid MMIS system. Upon receipt of payment the Waiver fiscal management agent completes the employer related responsibilities and forwards payment directly to the service worker for the services documented on the time sheet**.**

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1: COMPOSITE OVERVIEW

A. COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete a Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: NF

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1	$4,968	$6,895	$26,148	$ 9,725
2	$5,071	$7,033	$26,671	$ 9,920
3	$5,173	$7,174	$27,204	$10,118
4	$5,277	$7,317	$27,748	$10,320
5	$5,382	$7,463	$28,303	$10,526

B. FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS
1	811
2	850
3	850
4	850
5	850

EXPLANATION OF FACTOR C:

Check one:

____ The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

__X__ The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform CMS in writing of any limit which is less than factor C for that waiver year.

APPENDIX G-2: FACTOR D

METHODOLOGY FOR DERIVATION OF FORMULA VALUES

LOC: **NF**

The July 25, 1994 final regulation defines Factor D as:

> "The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following page.

APPENDIX G-2: FACTOR D

LOC: NF

Demonstration of Factor D estimates:

Waiver Year: 1 **X** 2 ____ 3 ____ 4 ____ 5 ____

Waiver Service (column A)	Unit Type (column B)	Number of Unduplicated Enrollees per Year (Column C)	Average Number of Annual Units per Enrollee (Column D)	Average Unit Cost (column E)	Total Annual Expenditure (column F)
Adult Day Health Services	Day	124	69	$36.92	$315,888
Homemaker Services	Hour	629	150	$19.46	$1,836,051
Respite Care Services	Hour	81	114	$20.38	$188,189
Respite Care Services – LTC Facility	Day	37	4	$93.68	$13,865
Waiver Case Management Services	15 minute	811	41	$18.11	$602,176
Enhanced State Plan Supportive Maintenance Home Health Aide	Hour	66	107	$21.04	$148,584
Adult Companion Services	15 minute	118	222	$2.75	$72,039
Chore Services	15 minute	88	36	$4.68	$14,826
Environmental Accessibility Adaptations	Each	1	2	$650.00	$1,300
Home Delivered Supplemental Meals	Per meal	322	105	$5.75	$194,408
Medication Reminder Services	Month	13	5	$33.00	$2,145
Personal Attendant Services – Participant employed Agency employed	15 minute hour	105 105	399 101	$2.85 $14.00	$119,400 $148,470 $267,870
Personal Attendant Program Training	15 minute	4	1	$15.00	$60
Personal Emergency Response Systems – Response Center Service	Month	562	5	$31.39	$88,206
Personal Emergency Response Systems – Purchase, Rental & Repair	Each	3	1	$199.00	$597
Personal Emergency Response – Installation, Testing & Removal	Each	47	1	$41.84	$1,966
Specialized Medical Equipment, Supplies, Assistive Technology	Each	275	4	$84.83	$93,313
Transportation Services - nonmedical	One-way	105	225	$7.59	$179,314
Fiscal Management Services	Month	105	12	$6.65	$8,379
GRAND TOTAL (sum of column F)					$4,029,176
TOTAL ESTIMATED UNDUPLICATED ENROLLEES					811
FACTOR D					$4,968
AVERAGE LENGTH OF STAY DURING WAIVER YEAR: 244					

APPENDIX G-2: FACTOR D

LOC: NF

Demonstration of Factor D estimates:

Waiver Year: 1 ___ 2 **X** 3 ___ 4 ___ 5 ___

Waiver Service (column A)	Unit Type (column B)	Number of Unduplicated Enrollees per Year (Column C)	Average Number of Annual Units per Enrollee (Column D)	Average Unit Cost (column E)	Total Annual Expenditure (column F)
Adult Day Health Services	Day	130	69	$37.66	$337,810
Homemaker Services	Hour	660	150	$19.85	$1,965,150
Respite Care Services	Hour	85	114	$20.79	$201,455
Respite Care Services – LTC Facility	Day	39	4	$95.55	$14,906
Waiver Case Management Services	15 minute	850	41	$18.47	$643,680
Enhanced State Plan Supportive Maintenance Home Health Aide	Hour	70	107	$21.46	$160,735
Adult Companion Services	15 minute	124	222	$2.81	$77,354
Chore Services	15 minute	93	36	$4.77	$15,970
Environmental Accessibility Adaptations	Each	2	2	$663.00	$2,652
Home Delivered Supplemental Meals	Per meal	338	105	$5.87	$208,326
Medication Reminder Services	Month	14	5	$33.66	$2,356
Personal Attendant Services – Participant employed	15 minute	111	399	$2.91	$128,881
Personal Attendant Services – Agency employed	Hour	111	101	$14.28	$160,093
Personal Attendant Program Training	15 minute	5	1	$15.30	$77
Personal Emergency Response Systems – Response Center Service	Month	590	5	$32.02	$94,459
Personal Emergency Response Systems – Purchase, Rental & Repair	Each	4	1	$202.98	$812
Personal Emergency Response – Installation, Testing & Removal	Each	50	1	$42.68	$2,134
Specialized Medical Equipment, Supplies, Assistive Technology	Each	289	4	$86.53	$100,029
Transportation Services - nonmedical	One-way	111	225	$7.74	$193,307
GRAND TOTAL (sum of column F)					$4,310,186
TOTAL ESTIMATED UNDUPLICATED ENROLLEES					850
FACTOR D					$5,071
AVERAGE LENGTH OF STAY DURING WAIVER YEAR: 244					

APPENDIX G-2: FACTOR D

LOC: NF

Demonstration of Factor D estimates:

Waiver Year: 1 ___ 2 ___ 3 X 4 ___ 5 ___

Waiver Service (column A)	Unit Type (column B)	Number of Unduplicated Enrollees per Year (Column C)	Average Number of Annual Units per Enrollee (Column D)	Average Unit Cost (column E)	Total Annual Expenditure (column F)
Adult Day Health Services	Day	130	69	$38.41	$344,538
Homemaker Services	Hour	660	150	$20.25	$2,004,750
Respite Care Services	Hour	85	114	$21.21	$205,525
Respite Care Services – LTC Facility	Day	39	4	$97.46	$15,204
Waiver Case Management Services	15 minute	850	41	$18.84	$656,574
Enhanced State Plan Supportive Maintenance Home Health Aide	Hour	70	107	$21.89	$163,956
Adult Companion Services	15 minute	124	222	$2.87	$79,005
Chore Services	15 minute	93	36	$4.87	$16,305
Environmental Accessibility Adaptations	Each	2	2	$676.26	$2,705
Home Delivered Supplemental Meals	Per meal	338	105	$5.99	$212,585
Medication Reminder Services	Month	14	5	$34.33	$2,403
Personal Attendant Services – Participant employed	15 minute	111	399	$2.97	$131,538
Personal Attendant Services – Agency employed	Hour	111	101	$14.57	$163,344
Personal Attendant Program Training	15 minute	5	1	$15.61	$78
Personal Emergency Response Systems – Response Center Service	Month	590	5	$32.66	$96,347
Personal Emergency Response Systems – Purchase, Rental & Repair	Each	4	1	$207.04	$828
Personal Emergency Response – Installation, Testing & Removal	Each	50	1	$43.53	$2,177
Specialized Medical Equipment, Supplies, Assistive Technology	Each	289	4	$88.26	$102,029
Transportation Services - nonmedical	One-way	111	225	$7.89	$197,053
GRAND TOTAL (sum of column F)					$4,396,944
TOTAL ESTIMATED UNDUPLICATED ENROLLEES					850
FACTOR D					$5,173
AVERAGE LENGTH OF STAY DURING WAIVER YEAR: 244					

APPENDIX G-2: FACTOR D

LOC: NF

Demonstration of Factor D estimates:

Waiver Year: 1 ____ 2 ____ 3 ____ 4 X 5 ____

Waiver Service (column A)	Unit Type (column B)	Number of Unduplicated Enrollees per Year (Column C)	Average Number of Annual Units per Enrollee (Column D)	Average Unit Cost (column E)	Total Annual Expenditure (column F)
Adult Day Health Services	Day	130	69	$39.18	$351,445
Homemaker Services	Hour	660	150	$20.66	$2,045,340
Respite Care Services	Hour	85	114	$21.63	$209,595
Respite Care Services – LTC Facility	Day	39	4	$99.41	$15,508
Waiver Case Management Services	15 minute	850	41	$19.22	$669,817
Enhanced State Plan Supportive Maintenance Home Health Aide	Hour	70	107	$22.33	$167,252
Adult Companion Services	15 minute	124	222	$2.93	$80,657
Chore Services	15 minute	93	36	$4.97	$16,640
Environmental Accessibility Adaptations	Each	2	2	$689.79	$2,759
Home Delivered Supplemental Meals	Per meal	338	105	$6.11	$216,844
Medication Reminder Services	Month	14	5	$35.02	$2,451
Personal Attendant Services – Participant employed	15 minute	111	399	$3.03	$134,196
Personal Attendant Services – Agency employed	Hour	111	101	$14.86	$166,595
Personal Attendant Program Training	15 minute	5	1	$15.92	$80
Personal Emergency Response Systems – Response Center Service	Month	590	5	$33.31	$98,265
Personal Emergency Response Systems – Purchase, Rental & Repair	Each	4	1	$211.18	$845
Personal Emergency Response – Installation, Testing & Removal	Each	50	1	$44.40	$2,220
Specialized Medical Equipment, Supplies, Assistive Technology	Each	289	4	$90.03	$104,075
Transportation Services - nonmedical	One-way	111	225	$8.05	$201,049
GRAND TOTAL (sum of column F)					$4,485,633
TOTAL ESTIMATED UNDUPLICATED ENROLLEES					850
FACTOR D					$5,277
AVERAGE LENGTH OF STAY DURING WAIVER YEAR: 244					

APPENDIX G-2: FACTOR D

LOC: NF

Demonstration of Factor D estimates:

Waiver Year: 1 ____ 2 ____ 3 ____ 4 ____ 5 **X**

Waiver Service (column A)	Unit Type (column B)	Number of Unduplicated Enrollees per Year (Column C)	Average Number of Annual Units per Enrollee (Column D)	Average Unit Cost (column E)	Total Annual Expenditure (column F)
Adult Day Health Services	Day	130	69	$39.96	$358,441
Homemaker Services	Hour	660	150	$21.07	$2,085,930
Respite Care Services	Hour	85	114	$22.06	$213,761
Respite Care Services – LTC Facility	Day	39	4	$101.40	$15,818
Waiver Case Management Services	15 minute	850	41	$19.60	$683,060
Enhanced State Plan Supportive Maintenance Home Health Aide	Hour	70	107	$22.78	$170,622
Adult Companion Services	15 minute	124	222	$2.99	$82,309
Chore Services	15 minute	93	36	$5.07	$16,974
Environmental Accessibility Adaptations	Each	2	2	$703.59	$2,814
Home Delivered Supplemental Meals	Per meal	338	105	$6.23	$221,103
Medication Reminder Services	Month	14	5	$35.72	$2,500
Personal Attendant Services – Participant employed	15 minute	111	399	$3.09	$136,853
Personal Attendant Services – Agency employed	Hour	111	101	$15.16	$169,959
Personal Attendant Program Training	15 minute	5	1	$16.24	$81
Personal Emergency Response Systems – Response Center Service	Month	590	5	$33.98	$100,241
Personal Emergency Response Systems – Purchase, Rental & Repair	Each	4	1	$215.40	$862
Personal Emergency Response – Installation, Testing & Removal	Each	50	1	$45.29	$2,265
Specialized Medical Equipment, Supplies, Assistive Technology	Each	289	4	$91.83	$106,155
Transportation Services - nonmedical	One-way	111	225	$8.21	$205,045
GRAND TOTAL (sum of column F)					$4,574,793
TOTAL ESTIMATED UNDUPLICATED ENROLLEES					850
FACTOR D					$5,382
AVERAGE LENGTH OF STAY DURING WAIVER YEAR: 244					

EXPLANATION OF D-CHART ESTIMATES

Reimbursement Units of Service for Covered Waiver Services

A. Adult Day Health Services - The Adult Day Health Services D-factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0247-90.R1, which serves a similar target population, trended forward to the first year of the renewal period (FY06) with adjustments for variance from the four-year trend. This covered service is reimbursed as a per day unit of service and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

B. Homemaker Services - The Homemaker Services D-factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0247-90.R1, which serves a similar target population, trended forward to the first year of the renewal period (FY06) with adjustments for variance from the four-year trend. This covered service is reimbursed as a per hour unit of service and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

C. Respite Care Services - The Respite Care Services D-factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0247-90.R1, which serves a similar target population, trended forward to the first year of the renewal period (FY06). This covered service is provided by home health aides or by entities or persons other than home health aides. This service is reimbursed as a per hour unit of service and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

D. Respite Care Services - LTC Facility - The Respite Care Services - LTC Facility D-factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0247-90.R1, which serves a similar target population, trended forward to the first year of the renewal period (FY06) with adjustments for variance from the four-year trend. This covered service is reimbursed as a per day unit of services and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

E. Waiver Case Management Services – The Waiver Case Management Services D-factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0247-90.R1, which serves a similar target population, trended forward to the first year of the renewal period (FY06) with adjustments for variance from the four-year trend. This covered service is reimbursed as a 15-minute unit of service and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

F. Enhanced State Plan Supportive Maintenance Home Health Aide Services – The Enhanced State Plan Supportive Maintenance Home Health Aide Services D-factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0247-90.R1, which serves a similar target population, trended forward to the first year of the renewal period (FY06) with adjustments for variance from the four-year trend. This covered services is reimbursed as a per hour unit of service and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

G. Adult Companion Services – The Adult Companion Services D-factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0247-90.R1, which serves a similar target population, trended forward to the first year of the renewal period (FY06) with adjustments for variance from the four-year trend. This covered service is reimbursed as a 15-minute unit of service and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

H. Chore Services - The Chore Services D-factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0247-90.R1, which serves a similar target population, trended forward to the first year of the renewal period (FY06). This covered service is reimbursed as a 15-minute unit of service and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

I. Environmental Accessibility Adaptations - The Environmental Accessibility Adaptations D-factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0247-90.R1, which serves a similar target population, trended forward to the first year of the renewal period (FY06) with adjustments for variance from the four-year trend. This covered service is reimbursed as a per service unit of service and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

J. Home Delivered Supplemental Meals - The Home Delivered Supplemental Meals D-factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0247-90.R1, which serves a similar target population, trended forward to the first year of the renewal period (FY06). This covered service is reimbursed as a per meal unit of service and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

K. Medication Reminder Systems - The Medication Reminder Systems D-factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0247-90.R1, which serves a similar target population, trended forward to the first year of the renewal period (FY06). This covered service is reimbursed as a per month unit of service and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

L. Personal Attendant Services - The Personal Attendant Services D-factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0247-90.R1, which serves a similar target population, trended forward to the first year of the renewal period (FY06) with adjustments for an outlier growth rate resulting from this service being added as a new service in the middle of the waiver authorization period. This covered service has two components: (a) a Participant-employed component reimbursed as a 15-minute unit of service and (b) an agency-employed component reimbursed as an hour unit of service. Each component has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

M. Personal Attendant Program Training - The Personal Attendant Program Training D-factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0247-90.R1, which serves a similar target population, trended forward to the first year of the renewal period (FY06). This covered service is reimbursed as a 15-minute unit of

service and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

N. Personal Emergency Response Systems, Response Center Service - The Personal Emergency Response Systems Response Center service D-factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0247-90.R1, which serves a similar target population, trended forward to the first year of the renewal period (FY06) with adjustments for variance from the four-year trend. This covered service is reimbursed as a monthly unit and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

O. Personal Emergency Response Systems, Purchase, Rental & Repair – The Personal Emergency Response Systems Purchase, Rental & Repair service D-factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0247-90.R1, which serves a similar target population, trended forward to the first year of the renewal period (FY06) with adjustments for variance from the four-year trend. This covered service is reimbursed as a per item unit and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

P. Personal Emergency Response Systems, Installation, Testing & Removal – The Personal Emergency Response Systems Installation, Testing & Removal service D-factor for FY06 is based on Form 372 initial reports for years 3 & 4 of waiver #0247-90.R1, which serves a similar target population, trended forward to the first year of the renewal period (FY06) with adjustments for variance from the four-year trend. This covered service is HCFA reimbursed as a per item unit and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

Q. Specialized Medical Equipment/Supplies/Assistive Technology – The Specialized Medical Equipment & Supplies D-factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0247-90.R1, which serves a similar target population, trended forward to the first year of the renewal period (FY06) with adjustments for variance from the four-year trend. This covered service is reimbursed as a per item unit of service and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

R. Transportation Services (Nonmedical) – The Transportation (Nonmedical) D-factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0247-90.R1, which serves a similar target population, trended forward to the first year of the renewal period (FY06) with adjustments for variance from the four-year trend. This covered service has two components: (a) one-way trip component and (b) a one-way stretcher van component. Both components are reimbursed as a one-way trip unit of service. Each component has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

APPENDIX G-3: METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual (e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

APPENDIX G-4: METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

X The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

____ The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

APPENDIX G-5: FACTOR D'

LOC: **NF**

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

> "The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

> The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.
>
> The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

> If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.
>
> Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

APPENDIX G-5: FACTOR D' (cont.)

LOC: **NF**

Factor D' is computed as follows (check one):

____ Based on HCFA Form 2082 (relevant pages attached).

__X__ Based on HCFA Form 372 lag reports for years 2 & 3 of waiver #0247-90.R1, which serves a similar target population. The results trended forward to the first year of the renewal period (FY06) is $6,895. An annual inflation factor of 2.0% is added for each year of waiver years two through five to compute the cost neutrality formulas for those years.

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

____ Other (specify):

APPENDIX G-6: FACTOR G

LOC: **NF**

The July 25, 1994 final regulation defines Factor G as:

> "The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

____ Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.

____ Based on trends shown by HCFA Form 372 for year ____of waiver #0247-90.R1, which reflect costs for an institutionalized population at this LOC.

____ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.

____ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

X Other (specify):

The 2004 Utah Legislature adopted legislation granting Medicaid nursing facilities a rate increase for FY05 that when added to the FY04 actual expenditures for NF services (actual factor G) will set the FY06 base at $26,148 (no inflation increase was given in FY05 to NFs). An annual inflation factor of 2.0% is added for each year of waiver years two through five.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

APPENDIX G-7: FACTOR G'

LOC: **NF**

The July 25, 1994 final regulation defines Factor G' as:

> "The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

> The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.
>
> The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

APPENDIX G-7: FACTOR G' (cont.)

LOC: **NF**

Factor G' is computed as follows (check one):

____ Based on HCFA Form 2082 (relevant pages attached).

____ Based on HCFA Form 372 lag reports for years ____ of waiver #0247-90.R1, which serves a similar target population.

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

_X_ Other (specify):

Based on actual average expenditures for the general Medicaid NF population for years 2 & 3 of waiver #0247-90.R1, which serves a similar target population. The results trended forward to the first year of the renewal period (FY06) is $9,725. An annual inflation factor of 2.0% is added for each year of waiver years two through five to compute the cost neutrality formulas for those years.

APPENDIX G-8: DEMONSTRATION OF COST NEUTRALITY

LOC: **NF**

YEAR 1

FACTOR D:	$ 4,968		FACTOR G:	$26,148
FACTOR D':	$ 6,895		FACTOR G':	$ 9,725
TOTAL:	$11,863	<	TOTAL:	$35,873

YEAR 2

FACTOR D:	$ 5,071		FACTOR G:	$26,671
FACTOR D':	$ 7,033		FACTOR G':	$ 9,920
TOTAL:	$12,104	<	TOTAL:	$36,591

YEAR 3

FACTOR D:	$ 5,173		FACTOR G:	$27,204
FACTOR D':	$ 7,174		FACTOR G':	$10,118
TOTAL:	$12,347	<	TOTAL:	$37,322

YEAR 4

FACTOR D:	$ 5,277		FACTOR G:	$27,748
FACTOR D':	$ 7,317		FACTOR G':	$10,320
TOTAL:	$12,594	<	TOTAL:	$38,068

YEAR 5

FACTOR D:	$ 5,382		FACTOR G:	$28,303
FACTOR D':	$ 7,463		FACTOR G':	$10,526
TOTAL:	$12,845	<	TOTAL:	$38,829

APPENDIX G-9: WAIVER SERVICES PROVIDER REIMBURSEMENT RATE SETTING METHODOLOGIES - MAXIMUM ALLOWABLE RATES

A. DEPARTMENT OF HUMAN SERVICES RESPONSIBILITY TO SET WAIVER RATES UNDER CONTRACT WITH THE DEPARTMENT OF HEALTH

The Department of Human Services (DHS) has entered into an administrative agreement with the Department of Health, Division of Health Care Financing (DHCF) to set 1915c HCBS waiver rates for waiver covered services. The DHS rate-setting process is designed to comply with requirements under the 1915c HCBS Waiver program and other applicable Medicaid rules. Since DHS usually sets rates at or close to the statistical mean, DHS also assures compliance with Medicaid payment requirements. Medicaid requires that rates for many services not exceed the prevailing charges. Prevailing charges are described at 42CFR § 405.504 and are set at the 75 percentile. The CFR lists other criteria regarding reasonable cost for Medicaid cost-of-service contracts when prevailing charge regulations do not apply. These are found and described at 42CFR § 405.501 and may be used as applicable.

B. AUTHORITY UNDER STATE DIVISION OF FINANCE RULE 33-3-217

DHS has the authority to set rates under the Utah State Department of Administrative Services (DAS), Division of Finance, Rule 33-3-217. This rule sets forth the parameters for open-ended, rate setting within DHS. Requirements for this rule are listed below.

1. All qualified providers can have a contract (no guarantee of placements).

2. DHS has a rate setting process that establishes reasonable rates.

3. DHS provides for due process to providers that have complaints.

C. COST PRINCIPLES

When setting rates and establishing budgets for cost of service contracts, DHS uses federal and department cost principles. These are described in the Bureau of Contract Management, Contract Information Manual, found on the DHS web site at http://www.hsofo.state.ut.us/Contract.htm. Additional references are given there for circulars containing the federal cost principles. These are issued by the federal Office of Management and Budget (OMB).

D. RATIONALE

1. The Department of Human Services has opted to provide many services using a fixed rate for multiple providers. This allows DHS the flexibility of using many providers across the state and increasing placement options across the state and within communities. Multiple providers are able to more readily respond to changing service demands. The DHS Bureau of Contract Management (BCM) has overall responsibility for the rate setting process within DHS. The setting of rates

is based on a cooperative process between BCM and each division within DHS. Each division is responsible to determine and define the service code and service components within each code. When a division establishes a new service code, they work with BCM to determine the rate to be set for that service. BCM also reviews rates on an ongoing basis and sets (establishes) a DHS Maximum Allowable Rate (MAR) level or Cap for that rate.

2. Each division determines the actual amount to be paid to providers that is not more than the MAR rate level. Divisions make this determination based on available budget and other considerations. Divisions continue to develop new services and to determine the initial payment rate (provisional rate) for those services. BCM will review the proposed new service code and consult with the division and DHCF on determining an acceptable initial rate for the service. BCM gives authorization for the initial (provisional) rate and forwards a rate request form to DCHF for input on MMIS.

E. OVERVIEW OF THE RATE SETTING METHODOLOGY

1. There are several methods DHS uses to reimburse providers of services to DHS individuals. The DHS Rate Handbook outlines the procedures for setting rates for DHS providers. These methodologies include the use of: (1) the Request for Proposal (RFP) process for cost-reimbursement contracts, (2) sole source contracts, and (3) rate-based unit-of-service contracts. This statement provides the authority and methodologies used for setting and reviewing the rates paid to providers using rate-based unit-of-service contracts with DHS.

2. DHS rates are set and paid on a prospective basis. This means that rates are set based on the market. Although actual costs may decrease or increase, providers are not expected or allowed to refund or bill for differences between actual current costs and rates. Rates are set based on the current market value of services rendered. This is sometimes referred to as the prevailing charge or rate. The nature and requirements of each of the services are defined by the various Divisions within DHS in accordance with the general description of those services outlined in the RFP and contract. Determination of current market value of services is determined by surveying current providers of such services to determine charges for those services or, in the alternate, the actual cost to provide services is used to set rates in lieu of market charges.

3. When data show the market value of services to be tightly clustered among various service providers, statistical measures of central tendency (e.g., mean, median, mode, and/or weighted average) are used. This establishes the most equitable rate that will assure a sufficient supply of service providers and concurrently pay a fair market rate. Measures of central tendency are best applied when data are clustered or normally distributed. When market conditions do not validate these assumptions, other measures will be allowed for use in setting rates for services including cost accounting measurements and/or those commonly used under Medicare or Medicaid programs. This also applies to rates receiving

Medicaid reimbursements.

4. To insure the greatest possible integrity of data supplied by providers, the staff from BCM or the DHS Bureau of Internal Review and Audit may audit data. In addition, non-representative (outlier) survey data may also be dropped from the survey if it is deemed to unfairly bias the results. An example of this would be a small service provider with exceptionally high or low rates that are not representative of the industry and market at large.

F. RATE SETTING METHODS

There are four principal methods used in setting the DHS Maximum Allowable Rate level. Each method is designed to determine a fair market rate. Because DHS provides services using various funding sources, including Title XIX, Title XX, Title IV-E among others, adjustments to the following processes may be deemed necessary on occasion to comply with funding requirements. Additionally, the process may be adjusted on occasion to account for common factors such as the geographical location of service delivery, absentee factors, or division budget constraints, etc.

1. Existing Market Survey or Cost Survey of Current Providers.

   This methodology surveys existing providers to determine their actual cost to render a service. This would include direct labor, supervision, administration, non-labor costs allocated to the purchased service and the basis of cost allocations. The surveys are designed to assure all providers are reporting costs in a standardized manner and within allowable costs parameters established by DHS. Surveys are examined to determine if cost definitions, allocations and reporting are consistent among respondents and accurately include reasonable costs of business. The rate is set using a measure of central tendency such as median, mode or weighted average and adjusted if necessary to reflect prevailing market conditions. (For example, a large provider may distort data and smaller providers may have substantially different costs. Failure to adjust for market realities may result in lack of available providers if the rate is set too low, or unnecessarily paying too much if the rate is set too high.)

2. Component Cost Analysis

   The estimated cost of each of the various components of a service code (rent, treatment, administration, direct labor, non-labor costs allocated to the service, etc) are determined and added together to determine a provisional rate. This method is often used for a new or substantially modified service that does not currently exist in the market place. Provisional rates are designed to determine a fair market rate until historical data becomes available. At a later date when historical cost data does become available a market survey may be undertaken to confirm or adjust the rate.

3. Comparative Analysis

This method may be used when a similar service exists. Adjustments are made to reflect any differences in the new service. Where possible and to provide consistency of payments in the provider community, rates are set to maintain common rates for common services purchased by various agencies. If a proposed service duplicates an existing service being used by another agency or program, the existing rate may be used to provide consistency of payments in the provider community, if the companion agency rate is considered to be in line with the market.

4. Community Price Survey

Where a broad based market exists for a service outside of DHS, existing service providers may be surveyed to determine the prevailing market price for the service. Again, measures of central tendency such as median, mode or weighted average are used and adjusted if necessary to reflect prevailing market.

G. DATA VALIDATION

The Utah Department of Human Services strives to utilize the most accurate information in the rate setting process. DHS uses various methods to validate data used in setting rates; these include both internal and external statistical and accounting tests. The specific methods used are determined by the type of data collected (i.e., from Cost Surveys, Market Surveys, Comparative Analysis, etc.), historical reliability of data sources and demands on staff. The type of tests used are based on the nature of the rate being set. Various methods of validation are explained in the DHS Rate Handbook.

H. COST OF LIVING ADJUSTMENTS (COLA'S)

1. Cost of Living Adjustments (COLA's) to the DHS MAR rate level are made annually, effective with the beginning of each state fiscal year. In general, changes in the twelve month period ending in June (base period) are reflected in an adjustment for the state fiscal year beginning twelve months later (effective date). This interim period is used to collect data from the base period, as it becomes available. The COLA adjustment is scheduled to be completed by the end of the calendar year to allow COLA information to be used in planning for the upcoming state fiscal year.

2. Changes in the MAR rates are based on changes in the cost of living as determined by broad based cost of living indices such as the Consumer Price Index (CPI-u) as published by the U.S. Department of Labor, or more representative local indices such as the Department of Workforce Services index of average Utah wages. The cost of living allowance is calculated by determining the percentage change in the index (or indices) and then applying that percentage change to the rate or rate components of established MAR rates. The MAR rates revisions are scheduled to be completed and published prior to the start of each state fiscal year.

3. COLA changes to a MAR are likely to be different from legislative rate changes funded in Division budgets. Legislative funding adjustments to Division rates are usually budget constrained and reflect a political perspective and may not be related to actual cost changes in rate components.

I. CAS MANAGEMENT SERVICES MONTHLY RATE

1. The Case Management covered waiver services provider rates are calculated using the cost survey of current providers methodology in general but includes an added procedure in which each fiscal year the Medicaid Single State Agency establishes specific cost center parameters to be used in calculating the annual MARs for waiver Case Management Services.

2. Case Management activities covered by the MARs must be consistent with the definitions of Case Management contained in Appendix B-1, and the Medicaid Home and Community-Based Services for Individuals Age 65 or Older provider manual.

3. Allowable Cost Centers

    a. Annual non-supervisory case management labor costs.

    b. Annual non-supervisory case management non-labor costs.

    c. Annual first line supervisory employee labor costs.

    d. Annual first line supervisory employee non-labor costs.

    e. Administrative costs associated with provision of case management service.

4. Case Management MAR Formula

$$\text{per unit rate} = \frac{[(a + b + c + d + e)]}{\text{total \# of service units per year}}.$$